

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19192

State File No. _____

FILED MAY 27 1957

4586

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or town) ST. LOUIS		c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 60 yrs		STREET ADDRESS (If rural, give location) 1510 Veronica Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION DEACONESS HOSPITAL			
3. NAME OF DECEASED (Type or Print) a. (First) ADELAIDE b. (Middle) M. c. (Last) RATZ		4. DATE OF DEATH (Month) (Day) (Year) MAY 13, 1957.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPT. 27, 1875.
9. AGE (In years) (last birthday) 81		10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <input type="checkbox"/> ST. CHARLES, MO.
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME DANIEL REINSMITH		13b. MOTHER'S MAIDEN NAME MARIE OBERKOETTER!	14. NAME OF HUSBAND OR WIFE ALBERT G. RATZ
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. NAOMI CLEMENT, 1629 HORNSBY AVE.
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Heart disease & TIA Interval between onset and death 4 days	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Heart Disease and Infarction		DUE TO (b) Arterial Hypertension arterial hypertension	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)		10 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 420.1			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 5/9 , 19 57 , to 5/13 , 19 57 , that I last saw the deceased alive on 5/13 , 19 57 and that death occurred at 11:50 AM , from the causes and on the date stated above.			
23a. SIGNATURE OF REGISTRAR Gay Simpson		23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 5/14/57
24a. BURIAL, CREMATION, REMOVAL, OR ENTOMBMENT		24b. DATE 5/16/57.	24c. NAME OF CEMETERY OR CREMATORY DAK GROVE MAUSOLEUM
24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CALVIN F. FEUTZ FUNERAL HOME, INC. 4828 Natural Bridge Blvd., St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAY 14 57		REGISTRAR'S SIGNATURE Carl Smith mjs (Licensed Embalmer's Statement on Reverse Side)	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *John A. Minard*

Licensed Embalmer No. *418*

P. O. Address *St. Louis*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.
If this body is not embalmed, fact should be so stated above.